Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Victor Turner a prisoner at HMP Wormwood Scrubs on 1 March 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Victor Turner died of lung cancer on 1 March 2016, while a prisoner at HMP Wormwood Scrubs. He was 72 years old. I offer my condolences to Mr Turner's family and friends.

Mr Turner had been diagnosed with terminal lung cancer before he was sent to prison in July 2013 and only palliative care was possible. Although the clinical reviewer identified some areas for improvement, these did not affect the outcome for Mr Turner and she was satisfied that his care was generally equivalent to that he would have received in the community. I therefore consider that Mr Turner received a satisfactory standard of care at Wormwood Scrubs.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 13 July 2013, Mr Victor Turner was remanded to HMP Wormwood Scrubs. (He was sentenced to six years in prison in June 2014.) Mr Turner had been diagnosed with terminal lung cancer in June 2012. He had had surgery and radiotherapy but the cancer was incurable. Shortly before he was sent to prison, he had been referred to palliative care services in the community. Mr Turner had a number of other health problems.

2. Prison doctors referred Mr Turner for tests for bowel cancer in August 2013 and for cognitive impairment in November 2013. These showed that the cancer had not spread to his bowel or his brain.

3. In July 2014, an oncologist reviewed Mr Turner and referred him for scans. In September, hospital doctors told Mr Turner that the scans showed that the cancer had spread to his other lung, his ribs and his pelvis. No curative treatment was possible.

4. From 4 November 2014, a palliative care nurse and palliative care consultant reviewed Mr Turner regularly. On 13 August 2015, the palliative care consultant told Mr Turner that he had just a few months to live. In October, Mr Turner appears to have agreed that he did not want anyone to resuscitate him if his heart or breathing stopped, but this decision was not formally recorded.

5. From January 2016, Mr Turner's condition deteriorated. On 18 February, Mr Turner had a seizure and was admitted to hospital, where a CT scan showed that the cancer had spread to his brain. Mr Turner was not restrained in hospital. On 22 February, the hospital began end of life care and on 25 February, the Governor released him on temporary licence. Mr Turner died on 1 March.

Findings

6. Overall, we consider that Mr Turner received a satisfactory standard of care at the prison. Although there were some delays in referring Mr Turner to palliative care services and for a scheduled oncology review, the clinical review did not consider these affected the outcome for Mr Turner. In her review, the clinical reviewer has made some recommendations for improvement in record keeping and access to services, which the Head of Healthcare will need to address. Overall she considered that although some of the care was reactive, Mr Turner's care was broadly equivalent to that he could have expected to receive in the community. We make no recommendations in this report.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Turner's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison.

10. We informed HM Coroner for West London of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Turner's son, to explain the investigation. His son did not have any specific matters for the investigation to consider.

12. The investigation has assessed the main issues involved in Mr Turner's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

13. Mr Turner's son received a copy of the initial report. He did not make any comments.

14. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Wormwood Scrubs

15. HMP Wormwood Scrubs is a large local prison in west London, holding over 1,200 men, either convicted or remanded by courts in the local area. It is also a designated resettlement prison for London prisoners. Central London Community Healthcare provides healthcare services. There is 24-hour healthcare cover and an inpatient unit with 17 beds.

HM Inspectorate of Prisons

16. The most recent inspection of Wormwood Scrubs was in December 2015. Inspectors had a number of concerns about the prison, but found that the quality of health services was reasonable with an adequate range of primary care services. The management of long-term conditions was mostly reasonable but few prisoners with long-term or complex conditions had care plans. The inpatient unit was a good environment. Most inpatients had severe mental health problems or other complex needs but there were often too few beds available to meet demand. The prison cancelled too many external hospital appointments due to a shortage of prison staff to take prisoners to hospital and this had a detrimental effect on prisoners' health. Inspectors found there was good support for prisoners who need palliative or end of life care.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB noted that healthcare services had received a commendable inspection report from the Care Quality Commission. The IMB was concerned that too many prisoners had hospital appointments cancelled, often due to a shortage of prison staff to take them.

Previous deaths at HMP Wormwood Scrubs

18. Mr Turner was the third prisoner to die from natural causes at Wormwood Scrubs since January 2014. There have been two other deaths from natural causes since Mr Turner died. There were no significant similarities with the circumstances of Mr Turner's death and the previous deaths.

Findings

The diagnosis of Mr Turner's terminal illness and informing him of his condition

19. Mr Turner was remanded to HMP Wormwood Scrubs on 13 July 2013. (He was subsequently sentenced to six years in prison for a violent offence on 19 June, 2014.)

20. In June 2012, Mr Turner had been diagnosed with lung cancer and had had surgery followed by radiotherapy. His condition was terminal and doctors did not plan any additional treatment. He had been referred for palliative care in the community but had not yet been seen by a Macmillan cancer nurse.

21. Mr Turner had a number of other health problems including cerebrovascular disease (a condition that affects the blood supply to the brain), renal failure (kidney disease), lower urinary tract symptoms and Barrett's oesophagus (ongoing heartburn and indigestion). In the months before he went to prison, Mr Turner had suffered from abdominal pain and alternating constipation and diarrhoea.

22. We are satisfied that Mr Turner was fully aware of his cancer diagnosis at the time he was remanded to prison.

Mr Turner's clinical care

23. On 17 July, a nurse practitioner contacted Macmillan nurses to refer Mr Turner and was told that they needed a doctor's referral. A doctor referred Mr Turner on 13 January 2014, but there is nothing in the records to explain the delay.

24. Nurses noted that Mr Turner often repeated himself and appeared forgetful. On 7 August 2013, a consultant psychiatrist referred Mr Turner for an MRI scan to check for a possible cognitive disorder. On 14 August, because of changes in his bowel habits, a prison GP referred Mr Turner urgently to a specialist for suspected cancer.

25. Investigations found that Mr Turner did not have bowel cancer and the cancer had not spread from his lungs. In November, Mr Turner had the MRI scan but there was no evidence that the cancer had spread to his brain.

26. On 16 March 2014, healthcare staff wrote a care plan to manage Mr Turner's reduced mobility, pain management and daily activities was created. Staff reviewed the care plan frequently.

27. On 17 June 2014, a modern matron contacted the oncology department at the hospital and requested an appointment for Mr Turner. On 10 July, Mr Turner had his first oncology review since he had arrived at the prison. She explained that this was because the hospital had sent Mr Turner's appointments to his home address and not to the prison. After this appointment, a doctor referred Mr Turner for scans.

28. On 18 September, Mr Turner had a follow up oncology appointment and was told that the scans had shown that the cancer had spread to another lung, part of his ribs and his pelvis bone. Oncologists concluded that Mr Turner would not benefit

from radiotherapy. They planned to see Mr Turner again on 11 December, but he refused to attend the appointment.

29. On 3 November, a psychologist began to support Mr Turner, after a request from a multidisciplinary team meeting. He saw Mr Turner weekly and they discussed his thoughts about his terminal illness and other issues concerning him. On 4 November, a clinical nurse specialist in palliative care visited Mr Turner. She recommended an increase in his pain medication, a urology review and a further oncology appointment.

30. On 5 February 2015, Mr Turner had the oncology appointment, but the consultant discharged him as Mr Turner found the appointments distressing and no treatment was possible.

31. The clinical nurse specialist and a palliative care consultant saw Mr Turner frequently. On 13 August 2015, the consultant told Mr Turner that he considered he had only a few months to live. At a palliative care review on 15 October, Mr Turner apparently agreed that he did not want to be resuscitated if his heart or breathing stopped, but there is no record of a formal 'do not resuscitate' order.

32. On 15 January 2016, a prison GP reviewed Mr Turner and recorded that he was deteriorating. On 29 January, the clinical nurse specialist reviewed his pain relief. On 15 February, a prison GP noted that Mr Turner was very frail and should be taken to hospital, if his condition deteriorated further.

33. On the evening of 18 February, Mr Turner fell out of bed and had a seizure. A prison GP examined him and arranged his admission to hospital. The next day, a CT scan showed that the cancer had spread to Mr Turner's brain. On 22 February, the hospital started end of life care. Mr Turner died on 1 March.

34. The clinical reviewer noted that some of Mr Turner's care was reactive, but concluded that it was generally equivalent to that he could have expected to receive in the community. Although there was a delay in oncology specialists reviewing Mr Turner, he had been seen in hospital for tests before that and this delay had no effect on his condition. He had a number of care plans to manage his symptoms and these were reviewed regularly. The clinical reviewer has made some recommendations for improvements, which the Head of Healthcare will need to address, but his overall care was satisfactory and met most of his identified needs. There was good continuity of care and staff aimed to make Mr Turner as comfortable as possible.

Mr Turner's location

35. Mr Turner was located in the healthcare unit from the time he arrived at Wormwood Scrubs in July 2013, initially because he had recently attempted suicide in the community. He stayed there throughout his time in prison.

36. On 20 March 2015, he was moved to a cell with a hospital bed and healthcare staff had access 24 hours a day. He had a duvet and a commode, and healthcare staff arranged extra clothes as he felt the cold. Nurses arranged for him to have a bath once a week as he felt cold when showering. In October 2015, they fitted safety rails to his bed, after he fell out.

37. In November 2015, the clinical nurse specialist asked the prison to consider moving Mr Turner to another prison with better facilities for his care. They examined the possibility of moving him to HMP Norwich, which has a special unit for older prisoners, but there were 18 men on the waiting list. We are satisfied that the prison appropriately tried to move Mr Turner to more suitable accommodation, and aimed to make him as comfortable as possible in the prison's healthcare centre.

Restraints, security and escorts

38. When prisoners have to travel outside prison, a risk assessment determines the nature and level of any security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

39. Mr Turner was taken to hospital for appointments a number of times during the course of his illness. He was usually accompanied by two officers and restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

40. However, when Mr Turner's condition deteriorated and he was admitted to hospital on 18 February 2016, a prison manager decided that he should not be restrained. We consider this was appropriate.

Liaison with Mr Turner's family

41. An officer was Mr Turner's prison family liaison officer. Mr Turner had not listed any next of kin, but a few weeks before he died, he asked her to find his two sons, who had not seen for over 40 years. She contacted the Salvation Army tracing service, but they could not locate either of his sons before Mr Turner's death. They traced one of his sons in April, one month after his death. He was able to attend the funeral, and the prison chaplaincy arranged for him to visit the prison and receive Mr Turner's property.

42. Mr Turner's funeral took place on 18 April. The prison arranged and paid for the funeral, in line with national instructions.

Compassionate release

43. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness, have a life expectancy of less than three months and meet other criteria.

44. On 15 February 2016, Mr Turner said that he wanted to die in prison and the prison did not apply for compassionate release on his behalf. We are satisfied this was appropriate and it was unlikely that he would have fulfilled the other criteria, particularly as he was terminally ill at the time of his sentence. From 25 February, the Governor released Mr Turner on temporary licence, with one officer accompanying for support.

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